STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF BISCOE	401 LAMBERT ROAD BISCOE, NC 27209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted onsite 5/19/21 and continued offsite through 5/21/21. One of the 3 complaint allegations was substantiated with a federal citation. See # MO2K11.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to follow transfer status when transferring a resident dependent on staff for assistance. The fall required a transfer to the emergency room for laceration to his head and a CT Scan to rule out further injury. This was for 1 (Resident #2) of 3 residents reviewed for accidents. The findings included Resident #2 was admitted on 8/10/18 and readmitted 4/3/21 with a diagnosis of Cerebral Vascular Accident (CVA) with left side hemiplegia. Resident #2' self-care deficit care plan dated 4/3/21 read he was a total lift with two-person assistance on 4/12/21. Resident #2's re-admission Minimum Data Set	F 689	Resident fell r/t CNA not using appropriate transfer method. Resident #2 sustained laceration to his head. He was evaluated at the ER, given some pain medication, and returned to the building with no new orders. To identify other residents that have the potential to be affected, an audit of current resident's□ transfer status was completed 5/7/2021 by the MDS Coordinator and the Director of Nursing. Care plans were validated to ensure the transfer status was accurate and triggered to the Kardex for Certified Nursing Assistants (CNAs) and Personal Care Assistants(PCAs) to access. To prevent this from recurring, all licensed	5/24/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/04/2021

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F 689	Continued From page 1 (MDS) dated 4/9/21 indicated he was cognitively intact and exhibited no behaviors. He was coded for extensive assistance with transfers, impairment on one side upper and lower extremities and as having no falls. Resident #2's Fall Care Area Assessment (CAA) dated 4/9/21 read he was alert and oriented and able to make his needs known. Resident #2 wanted to be able to stand and transfer Independently, but he has not walked in at least a year. The facility incident report dated 5/6/21 at 7:30 PM read Resident #2 was being transferred to the bedside commode by Nursing Assistants (NA) #1 and NA #2. The wheelchair brakes were unlocked. The aides were attempting to get Resident #2 off the bedside commode when his legs gave out. Resident #2 was lying on his back and his head hit the bottom of the bed resulting in a laceration to the back of his head. He was transferred to the emergency room for an assessment. Resident #2's emergency room records dated 5/6/21 read his CT Scan was normal and he had a minor head trauma. An abrasion was noted to his left parietal area. There was no treatment for the laceration and there were no new orders and he returned to facility with neurological checks. A telephone interview was conducted on 5/20/21 at 3:35 PM with NA #2. She stated she was hired sometime in March 2021. She stated NA #1 asked her to assist with transferring Resident #2 from the wheelchair to his bedside commode. She stated NA #1 lifted Resident #2 by placing	F 689	nurses, CNAs and PCAs were reeducated concerning the expectation that the designated transfer process only be used and reviewing the Kardex with each assignment to ensure awareness of resident's current transfer process. This education was completed by the Director of Nursing or designee by 5/11/2021. Any licensed staff, CNAs and PCAs that cannot be reached within the initial reeducation time frame, will not take an assignment until they have received this reeducation. Agency licensed nurses and newly hired licensed nurses, CNAs and PCAs will have this education regarding transfers by therapy personnel with return demonstration during their orientation. To monitor and maintain ongoing compliance, transfers will be observed by the Director of Nursing or designee. Nursing staff will be interviewed concerning the transfer process for residents. This will be documented at least one transfer a day for 7 days, at least one transfer a day 5 days a week for 3 weeks, and then at least one a week for 8 weeks. As of 5/24/2021, there have been no issues with transfers and transfer status. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and	

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F 689	Continued From page 2	F 689		

her arms under his arms with him lying on her chest. When Resident #2 was finished using the bedside commode, NA #1 again lifted him in the same fashion. NA #2 stated she cleaned Resident #2 and was applying a new brief when he fell. NA #2 stated Resident #2 was a total lift prior to this fall and stated two staff members had to be present when using a total lift.

A telephone interview was conducted on 5/2021 at 3:46 PM with NA #1. She stated she was hired sometime in March 2021. NA #1 stated 5/6/21 was the first time she had worked with Resident #2, so she asked him if he was a total lift and he stated he did not need the assistance of a lift for transfers. She stated she lifted him up from the wheelchair under his arms and put him on the bedside commode. When he was finished, she stated she lifted him up again in the same fashion while NA #2 cleaned him up. That was when he fell backwards. She stated NA #2 should have said something to her about him needing to transferred using the lift. NA #1 stated she never saw Resident #2's electronic Kardex because nobody showed her how to see it. She stated she may have been shown in orientation, but nobody had showed her since then. She confirmed she did not ask anyone to assist her with accessing the electronic Kardex. She stated Resident #2 was on the 400 hall prior to transferring to the 100 hall so she was not familiar with how he was to be transferred.

Resident #2's electronic medical record revealed he moved from the 400 hall to the 100 hall on 4/23/21. The facility provided documentation that NA #1 was assigned Resident #2 on the following dates: 4/23/21, 4/26/21, 4/28/21, 4/29/21, 4/30/21, 5/5/21 and 5/6/21. This indicated she

recommendations for the time frame of the monitoring period or as it is amended by the committee.

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F 689	Continued From page 3	F 689		

worked with Resident #2 on 400 and 100 halls.

A telephone interview was conducted on 5/20/21 at 5:48 PM with Nurse #1. She stated she was assigned Resident #2 on 5/6/21 when he fell. Nurse #1 stated NA #1 told her that she never used a lift to transfer him but should have used the lift because he was known to go limp during transfers. She assessed Resident #2 and noted a laceration to his head where he hit his head on the bed frame and complaints of shoulder pain. She stated she called the MD and she gave orders to send him out to the emergency room for an evaluation.

An observation and interview were conducted on 5/19/21 at 2:30 PM with Resident #2. He was in his room sitting in his wheelchair. He recalled the fall and stated NA #1 was helped him stand and pivot from his wheelchair to his bedside commode. He stated she had been transferring him that way. He stated he did not think he needed to be transferred with the total lift. Resident #2 stated his leg gave out and he fell backwards. He stated his head hit the side of his bed that resulted in a laceration. Resident #2 stated he was sent to the emergency room due to the laceration and pain to his left shoulder. He stated his CT Scan was negative for any head injuries and x-ray of his shoulder did not reveal any injury.

Review of Resident #2's Medical Director (MD) progress note dated 5/11/21 read he was seen due to an acute fall. The aide was helping him transfer when he lost his balance, falling backward against the bed. He hit his neck and head and was seen in the emergency room. His head CT Scan was negative for injuries. The note

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F 689	Continued From page 4	F 689		

read Resident #2 and the staff were aware of the possible need for a lift with transfers since he was unable to use his left side to aide in pivots or balance.

A telephone interview was conducted on 5/20/21 at 10:07 AM with the Nurse Practitioner (NP). She stated he was known to suddenly go limp and that Resident #2 was very unpredictable. NP stated Resident #2 should have been transferred using a total lift with two staff present. NP stated Resident #2's fall on 5/6/21 was avoidable if NA #1 and NA #2 had followed the recommended transfer method of the lift.

A telephone interview was conducted on 5/20/21 at 1:04 PM with the Director of Nursing (DON). She stated it was her expectation that NA #1 and NA #2 used a total lift for Resident #2's transfer on 5/6/21. She stated she thought Resident #2's fall could have been prevented if the aides transferred him properly.

A telephone interview was conducted on 5/20/21 at 3:13 PM with the MD. She stated it was her expectation that facility staff follow the established method of transferring Resident #2. She stated Resident #2's fall could have been prevented if the staff followed the Kardex by using a total lift at the time of his fall on 5/6/21.